	FO	R OHF	USE		

LL1

2004 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2004)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 LCS 4/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0041020		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: Heritage Manor-Colfax		
		61728	I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004
	Number City Z	Zip Code	and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with
	County: McLean		applicable instructions. Declaration of preparer (other than provider)
	Telephone Number: (309) 697-6636 Fax # ()		is based on all information of which preparer has any knowledge.
	IDPA ID Number: 370909086001		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.
	Date of Initial License for Current Owners: 1963		(Signed)
			Officer or (Date)
	Type of Ownership:		Administrator (Type or Print Name) Craig L. Ater
	VOLUNTARY,NON-PROFIT XX PROPRIETARY GOVE	ERNMENTAL	of Provider (Title) Senior V.P., and Chief Financial Officer
		State	<u> </u>
	Trust Partnership (County	(Signed)
	IRS Exemption Code Corporation C	Other	(Date)
	xx "Sub-S" Corp.		Paid (Print Name
	Limited Liability Co.		Preparer and Title)
	Trust Other		(Firm Name
	Other		& Address)
			(Telephone) (309)823-7135 Fax#()
			MAIL TO: OFFICE OF HEALTH FINANCE
	In the event there are further questions about this report, please contact: Name: Telephone Number: ()		ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East
	Name: Telephone Number:		Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Facility Name & ID Numb	er Heritage Mai	nor-Colfax				# 0041020 Report Period Beginning: 01/01/2004 Ending: 12/31/2004
III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
A. Licensure/c	ertification level(s) of	care; enter number	of beds/bed days,			(Do not include bed-hold days in Section B.)
(must agree	with license). Date of	change in licensed b	eds		_	
						E. List all services provided by your facility for non-patients.
1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
						None
Beds at				Licensed		
Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? yes
Report Period	Level of C	Care	Report Period	Report Period		
						G. Do pages 3 & 4 include expenses for services or
1 60	Skilled (SNF	F)	60	21,960	1	investments not directly related to patient care?
2	Skilled Pedia	atric (SNF/PED)			2	YES NO xx
3	Intermediat	e (ICF)			3	
4	Intermediat	e/DD			4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5	Sheltered Ca	are (SC)			5	YES NO xx
6	ICF/DD 16 o	or Less			6	
						I. On what date did you start providing long term care at this location?
7 60	TOTALS		60	21,960	7	Date started 1963
D.C. E						J. Was the facility purchased or leased after January 1, 1978?
B. Census-For	the entire report per				1	YES Date NO xx
1	2	3	4	5		77 TV -1 A NI - 10 14 TV -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1 -1
Level of Care	Patient Days Public Aid	by Level of Care an	d Primary Source of	Payment		K. Was the facility certified for Medicare during the reporting year?
		D-24- D	Other	T-4-1		YES xx NO If YES, enter number
O CAME	Recipient	Private Pay	Other	Total		of beds certified and days of care provided 1,809
8 SNF 9 SNF/PED	5,471	8,509	1,809	15,789	8	M.P. T. P. M. J.CO. J.
			0		9	Medicare Intermediary Mutual of Omaha
10 ICF 11 ICF/DD					10 11	IV. ACCOUNTING BASIS
12 SC	0	0	0	+	12	MODIFIED
13 DD 16 OR LESS	U	U	U		13	
13 DD 10 OK LESS					13	ACCRUAL XX CASH* CASH*
14 TOTALS	5,471	8,509	1,809	15,789	14	Is your fiscal year identical to your tax year? YES xx NO
C. Percent Occ	cupancy. (Column 5,	line 14 divided by to	tal licensed			Tax Year: Fiscal Year:
	line 7, column 4.)	71.90%				* All facilities other than governmental must report on the accrual basis.
			_			

STATE	OF ILL	INOIS			
	- 11	0041030	n (n'in''	01/01/2004	17 10

	Facility Name & ID Number	Heritage Manor			STATE OF ILI #	LINOIS 0041020	Report Period	Beginning:	01/01/2004	Ending:	Page 3 12/31/2004	_
	V. COST CENTER EXPENSES (through		<u>please round to</u> osts Per Genera		llar)	Reclass-	Reclassified	Adjusted	FOR OHE	USE ONLY	Т	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	Adjust- ments	Total	FOR OIII	USE ONLI	
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	138,783	7,501		146,284	Ü	146,284	2,240	148,524		1	1
2	Food Purchase	,	51,802		51,802		51,802	,	51,802			2
3	Housekeeping	41,492	10,158		51,650		51,650		51,650			3
4	Laundry	36,554	4,807		41,361		41,361		41,361			4
5	Heat and Other Utilities			47,288	47,288		47,288	686	47,974			5
6	Maintenance	30,697	24,233	23,662	78,592		78,592	8,036	86,628			6
7	Other (specify):*											7
8	TOTAL General Services	247,526	98,501	70,950	416,977		416,977	10,962	427,939			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	649,285	39,841	47,466	736,592		736,592		736,592			10
10a	Therapy		135,182	137,556	272,738	(209,533)	63,205	64,467	127,672			10a
11	Activities	25,929	892		26,821		26,821		26,821			11
12	Social Services	24,271		2,889	27,160		27,160		27,160			12
13	Nurse Aide Training	354	101		455		455	1,187	1,642			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	699,839	176,016	195,111	1,070,966	(209,533)	861,433	65,654	927,087			16
	C. General Administration											
17	Administrative	51,597			51,597		51,597	40,339	91,936			17
18	Directors Fees							3,262	3,262			18
19	Professional Services			143,709	143,709		143,709	(133,453)	10,256			19
	Dues, Fees, Subscriptions & Promotions			48,408	48,408	(32,940)	15,468	(4,009)	11,459			20
21	Clerical & General Office Expenses	69,544	5,785	12,237	87,566		87,566	81,203	168,769			21
22	Employee Benefits & Payroll Taxes			220,804	220,804		220,804	20,918	241,722			22
23	Inservice Training & Education			1,021	1,021		1,021	332	1,353			23
24	Travel and Seminar			4,637	4,637		4,637	(2,638)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			37,833	37,833		37,833	1,224	39,057			26
27	Other (specify):*											27
28	TOTAL General Administration	121,141	5,785	468,649	595,575	(32,940)	562,635	7,178	569,813			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,068,506	280,302	734,710	2,083,518	(242,473)	1,841,045	83,794	1,924,839			29

**Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

#0041020

Report Period Beginning:

01/01/2004 Ending:

Page 4 12/31/2004

V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			65,849	65,849		65,849	6,976	72,825			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			38,864	38,864		38,864	(79)	38,785			32
33	Real Estate Taxes			28,620	28,620		28,620		28,620			33
34	Rent-Facility & Grounds							3,971	3,971			34
35	Rent-Equipment & Vehicles			5,422	5,422		5,422	(783)	4,639			35
36	Other (specify):*											36
37	TOTAL Ownership			138,755	138,755		138,755	10,085	148,840			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					209,533	209,533		209,533			39
40	Barber and Beauty Shops		5	4,857	4,862		4,862		4,862			40
41												41
42	Provider Participation Fee					32,940	32,940		32,940			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		5	4,857	4,862	242,473	247,335		247,335			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,068,506	280,307	878,322	2,227,135		2,227,135	93,879	2,321,014			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heritage Manor-Colfax

0041020 **Report Period Beginning:** 01/01/2004

Ending:

Page 5 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,346)	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(79)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(328)	20		17
18	Fines and Penalties				18
19	Entertainment	(7,540)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,075)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(5,886)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (17,254)		\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	_	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	111,133		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 111,133		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 93,879		37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.) 1 2

3

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Page 5A

Heritage Manor-Colfax

| ID# | 0041020 | Report Period Beginning: 01/01/2004 | Ending: 12/31/2004

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	\$			1
2				2
3				3
4				4
5		(2,346)	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16		-	24	16
17		(328)	20	17
18		(320)		18
19			24	19
20		0	27	20
21		U	21	21
22		(1,075)	19	22
23		(1,073)	19	23
24		0	27	24
25		(5,886)	20	25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37		·		37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
48 49 Total		(9,635)	-	48
47 I Utai		(8,035)	1	49

Summary A Facility Name & ID Number Heritage Manor-Colfax 01/01/2004 Ending: 12/31/2004 # 0041020 Report Period Beginning:

	SUMMARY OF PAGES 5, 5A, 6, 6A	A, 6B, 6C, 6D, 6	6E, 6F, 6G, 6F	I AND 6I										
													SUMMARY	1
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	1
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6I	(to Sch V, col	.7)
1	Dietary	0	0	2,240	0	0	0	0	0	0	0	0	2,240	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	686	0	0	0	0	0	0	0	0	686	5
6	Maintenance	0	0	8,036	0	0	0	0	0	0	0	0	8,036	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	10,962	0	0	0	0	0	0	0	0	10,962	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	64,467	0	0	0	0	0	0	0	0	0	64,467	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,187	0	0	0	0	0	0	0	0	1,187	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	64,467	1,187	0	0	0	0	0	0	0	0	65,654	16
	C. General Administration													
17	Administrative	0	0	40,339	0	0	0	0	0	0	0	0	40,339	17
18	Directors Fees	0	0	3,262	0	0	0	0	0	0	0	0	3,262	18
19	Professional Services	(1,075)	(142,634)	10,256	0	0	0	0	0	0	0	0	(133,453)	19
20	Fees, Subscriptions & Promotions	(6,214)	0	2,205	0	0	0	0	0	0	0	0	(4,009)	20
21	Clerical & General Office Expenses	0	0	81,203	0	0	0	0	0	0	0	0	81,203	21
22	Employee Benefits & Payroll Taxes	0	0	20,918	0	0	0	0	0	0	0	0	20,918	22
23	Inservice Training & Education	0	0	332	0	0	0	0	0	0	0	0	332	23
24	Travel and Seminar	(7,540)	0	4,902	0	0	0	0	0	0	0	0	(2,638)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,224	0	0	0	0	0	0	0	0	1,224	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(14,829)	(142,634)	164,641	0	0	0	0	0	0	0	0	7,178	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(14,829)	(78,167)	176,790	0	0	0	0	0	0	0	0	83,794	29

STATE OF ILLINOIS

Heritage Manor-Colfax

0041020 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Facility Name & ID Number

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6I	(to Sch V, col.	.7)
30	Depreciation	0	0	0	6,976	0	0	0	0	0	0	0	6,976	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(79)	0	0	0	0	0	0	0	0	0	0	(79)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	3,971	0	0	0	0	0	0	0	3,971	34
35	Rent-Equipment & Vehicles	(2,346)	0	0	1,563	0	0	0	0	0	0	0	(783)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,425)	0	0	12,510	0	0	0	0	0	0	0	10,085	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(17,254)	(78,167)	176,790	12,510	0	0	0	0	0	0	0	93,879	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

t. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule in necessary.									
1	•	2				3			
OWNERS		RELATED NURSING HOMES				OTHER RELATED BUSINESS ENTITIES			
Name	Ownership %	Name	City			Name	City		Type of Business
		,,,,,							
B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent,									

management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization		7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V s				\$	\$	1		
2	V	10a	Adjustment for Related Organizat	tion 22,148	GreenTree Therapy	100.00%	21,338	(810)	2
3	V								3
4	V	19	Adjustment for Related Organizat	tion 142,634	Heritage Enterprises, Inc.	100.00%		(142,634)	4
5	V								5
6	V	10a	Adjustment for Related Organizat	tion 134,643	GreenTree Pharmacy	100.00%	199,920	65,277	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			s 299,425			\$ 221,258	\$ * (78,167)	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS	Page 6A
-------------------	---------

Facility Name & ID Number	Heritage Manor-Colfax	#	0041020	Report Period Beginning:	01/01/2004	Ending:	12/31/2004	
VII. RELATED PARTIES (contin B. Are any costs included in this management fees, purchase of	report which are a result of transactions with related organizations? This in	cludes ren	t,					
If yes, costs incurred as a rest	ılt of transactions with related organizations must be fully itemized in accord	ance with						

the instructions for determining costs as specified for this form.

1 2		1	or determining costs as specified for		- a		_	0. 7144	
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
							Operating Cost	Adjustments for	
Scho	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership Organization		Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 2,240	\$ 2,240 1:	15
16	V	2	Food Purchase				0	1	16
17	V	3	Housekeeping				0	1'	17
18	V	4	Laundry				0	1	18
19	V	5	Heat & Other Utilities				686	686 1	19
20	V	6	Maintenance				8,036	8,036 2	20
21	V	7	Other				0	2	21
22	V	9	Medical Director				0	2	22
23	V	10	Nursing & Medical Records				0	2	23
24	V	11	Activities				0	2	24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				1,187	1,187 2	26
27	V	14	Program Transportation				0	2	27
28	V	15	Other				0		28
29	V	17	Administrative				40,339	40,339 2	29
30	V	18	Directors Fees				3,262		30
31	V	19	Professional Services				10,256	10,256 3	31
32	V	20	Fees, Subscription, Promotions				2,205		32
33	V	21	Clerical & General Office Expenses				81,203		33
34	V	22	Employee Benefits & Payroll Taxes				20,918		34
35	V	23	Inservice Training & Education				332	332 3	35
36	V	24	Travel and Seminar				4,902	4,902 3	36
37	V	25	Other Admin. Staff Transportation				0	_	37
38	V	26	Insurance-Prop.Liab.Malpract				1,224	1,224 3	38
39	Total			\$			s 176,790	s * 176,790 3	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS	Page 6B
-------------------	---------

Facility Name & ID Number Heritage Man	or-Colfax	#	0041020	Report Period Beginning:	01/01/2004	Ending:	12/31/2004	
VII. RELATED PARTIES (continued) B. Are any costs included in this report which are management fees, purchase of supplies, and so	re a result of transactions with related organizations? This inclu of forth. YES NO	des rer	ıt,					
If yes, costs incurred as a result of transaction	s with related organizations must be fully itemized in accordan	ce with						

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	the moti t		or determining costs as specified for			1	I		
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
							Operating Cost	Adjustments for	
Scho	dule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	1
						Ownership	Organization	Costs (7 minus 4)	
15	V		Other	\$	Heritage Enterprises, Inc.		\$	*	15
16	V	30	Depreciation				6,976	6,976	16
17	V	31	Amortization of Pre-Op & Org				0		17
18	V		Interest				0		18
19	V		Real Estate Taxes				0		19
20	V		Rent-Facility & Grounds				3,971	3,971	20
21	V	35	Rent-Equipment & Vehicles				1,563	1,563	21
22	V	36	Other				0		22
23	V	38	Medically Nec Transportation				0		23
24	V	39	Ancillary Service Centers				0		24
25	V	40	Barber and Beauty Shops				0		25
26	V	41	Coffee and Gift Shops				0		26
27	V	42	Other				0		27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V			_					37
38	V								38
39	Total			\$			s 12,510	s * 12,510	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS Page 7

Facility Name & ID Number Heritage Manor-Colfax # 0041020 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6	i	7		8	
						Average Hours Per Work					
					Compensation	Week Devo	Week Devoted to this		Compensation Included		
					Received	Facility and	% of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Susie Jefferson	Director	Management	15.86		10		Salary/BOD	\$ 1,996	Ln. 17/18	1
2	Tom Jefferson	Secretary	Management	16.21		10		Salary/BOD	8,566	Ln. 17/18	2
3	Craig Hart		Management	31.95		10		Salary/BOD	10,846	Ln. 17/18	3
4	Cheryl Lowney	Executive Vice Presid	Management	0.49		40	100.00	Salary/BOD	5,900	Ln. 17/18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	7,870	Ln. 17/18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	3,912	Ln. 17/18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	4,511	Ln. 17/18	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 43,601		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS Page 8

Facility Name & ID Number	Heritage Manor-Colfax	#	0041020	Report Period Beginning:	01/01/2004	Ending:	2/31/2004	
VIII. ALLOCATION OF INDIR	ECT COSTS			 -				
,,				Name of Related	d Organization			
A. Are there any costs include	d in this report which were derived from	allocations of central office	ee	Street Address	•			
or parent organization cost	s? (See instructions.) YES	NO		City / State / Zip	Code			

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization			
Street Address			
City / State / Zip Code			
Phone Number	()	
Fax Number	()	

		2	2					0	0	$\overline{}$
		2	3	4	5	6	/	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	1	Dietary	Beds	2,403	24	\$ 89,729	\$ 89,729	60	\$ 2,240	1
2	2	Food Purchase	Beds	2,403	24	0	0	60	0	2
3	3	Housekeeping	Beds	2,403	24	0	0	60	0	3
4	4		Beds	2,403	24	0	0	60	0	4
5	5	Heat & Other Utilities	Beds	2,403	24	27,471	0	60	686	5
6	6	Maintenance	Beds	2,403	24	321,832	76,617	60	8,036	6
7			Beds	2,403	24	0	0	60	0	7
8	9	Medical Director	Beds	2,403	24	0	0	60	0	8
9	10	Nursing & Medical Records	Beds	2,403	24	0	0	60	0	9
10			Beds	2,403	24	0	0	60	0	10
11			Beds	2,403	24	0	0	60	0	11
12	13	Nurse Aide Training	Beds	2,403	24	47,533	39,159	60	1,187	12
13	14	Program Transportation	Beds	2,403	24	0	0	60	0	13
14			Beds	2,403	24	0	0	60	0	14
15	17	Administrative	Beds	2,403	24	1,615,588	1,615,588	60	40,339	15
16	18	Directors Fees	Beds	2,403	24	130,630	0	60	3,262	16
17			Beds	2,403	24	410,747	0	60	10,256	17
18			Beds	2,403	24	88,297	0	60	2,205	18
19	21	Clerical & General Office Expense	Beds	2,403	24	3,252,161	2,929,944	60	81,203	19
20		Employee Benefits & Payroll Taxe	Beds	2,403	24	837,746	0	60	20,918	20
21	23	8	Beds	2,403	24	13,283	0	60	332	21
22	24	Travel and Seminar	Beds	2,403	24	196,325	0	60	4,902	22
23		Other Admin. Staff Transportatio	Beds	2,403	24	0	0	60	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,403	24	49,040	0	60	1,224	24
25	TOTALS					\$ 7,080,382	\$ 4,751,037		\$ 176,790	25

STATE OF ILLINOIS	Page 8A

Facility Name & ID Number	Heritage Manor-Colfax	#	0041020	Report Period Beginning:	01/01/2004	Ending:	2/31/2004	
VIII. ALLOCATION OF INDIRE	ECT COSTS			 -				
				Name of Related	l Organization			
A. Are there any costs included	d in this report which were derived from allocations of central	offic	e	Street Address				
or parent organization costs	s? (See instructions.) YES NO			City / State / Zip	Code			
				Phone Number		()		
B. Show the allocation of costs	below. If necessary, please attach worksheets.			Fax Number		()		

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	27	Other	Beds	2,403	24	\$	\$	60	\$	1
2	30	Depreciation	Beds	2,403	24	279,369		60	6,976	2
3	31	Amortization of Pre-Op & Org	Beds	2,403	24			60		3
4		Interest	Beds	2,403	24			60		4
5		Real Estate Taxes	Beds	2,403	24			60		5
6		Rent-Facility & Grounds	Beds	2,403	24	159,040		60	3,971	6
7		Rent-Equipment & Vehicles	Beds	2,403	24	62,608		60	1,563	7
8			Beds	2,403	24			60		8
9	38		Beds	2,403	24			60		9
10	39	Ancillary Service Centers	Beds	2,403	24			60		10
11		Barber and Beauty Shops	Beds	2,403	24			60		11
12		Coffee and Gift Shops	Beds	2,403	24			60		12
13	42	Other	Beds	2,403	24			60		13
14								60		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 501,017	\$		\$ 12,510	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
												Reporting	
					Monthly					Maturity	Interest	Period	
	Name of Lender	Related	l**	Purpose of Loan	Payment	Date of		nount o	of Note	Date	Rate	Interest	
		YES	NO		Required	Note	Origina	l	Balance		(4 Digits)	Expense	
	A. Directly Facility Related												
	Long-Term												
1	LsSalle National Bank		XX	Mortgage	4640 plus Int	01/15/99	\$	\$	722,502	01/15/06	variable	\$ 26,72	
2	LsSalle National Bank		XX	Mortgage								5,484	4 2
3													3
4													4
5													5
	Working Capital							·					
6	Central Office Allocation		XX	Working Capital								6,65	2 6
7	Central Office Allocation		XX	Working Capital									7
8													8
9	TOTAL Facility Related						\$	\$	722,502			\$ 38,86	4 9
	B. Non-Facility Related*												
10	Interest Income											(7:	9) 10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$	\$				\$ (79	9) 14
									•				
15	TOTALS (line 9+line14)						\$	\$	722,502			\$ 38,78	5 15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$	Line #
---	----	--------

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
0041020 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

Facility Name & ID Number Heritage Manor-Colfax

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

D. Real Estate Taxes						
Real Estate Tax accrual used on 2003 report.	<i>Important</i> , please see the next worksheet, bill must accompany the cost report.	, "RE_Tax". The real	estate tax statement and	s	24,803	1
2. Real Estate Taxes paid during the year: (Indicat	te the tax year to which this payment applies. If payment cover	ers more than one year, de	tail below.)	s	26,060	2
3. Under or (over) accrual (line 2 minus line 1).				\$	1,257	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the line	es below.)		\$	27,363	4
**	ich has NOT been included in professional fees or other gene copies of invoices to support the cost and a co			s		5
6. Subtract a refund of real estate taxes. You must classified as a real estate tax cost plus one-half of TOTAL REFUND \$ For	2 11	eal estate tax appeal	board's decision.)	s		6
7. Real Estate Tax expense reported on Schedule	V, line 33. This should be a combination of lines 3 thru 6.			\$	28,620	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year:	1999 17,575 8		FOR OHF USE ONLY			
	2000 20,995 9 2001 26,915 10	13	FROM R. E. TAX STATEMENT FO	OR 2003 \$		1
	2002 25,138 11 2003 25,336 12	14	PLUS APPEAL COST FROM LINE	Ē 5 \$		1
		15	LESS REFUND FROM LINE 6	•		
		15	LESS REPUND FROM LINE 0	<u> </u>		1

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	Heritage Manor-C	olfax			COUNTY	McLean	
FAC	ILITY IDPH LICI	ENSE NUMBER	0041020					
CON	TACT PERSON I	REGARDING THIS	REPORT					
TEL	EPHONE ()		FAX#: ()			
A.	Summary of Re	al Estate Tax Cost						
	cost that applies thome property w	to the operation of th hich is vacant, rented	state tax assessed for 2 e nursing home in Col I to other organization cost for any period ot	umn D. Real esta s, or used for purp	te tax a	applicable to ther than long	any portion o	f the nursing
	(A)	(B)			(C)		(D)
	Tax Index	<u>Number</u>	Property Descr	i <u>ption</u>		Total Tax		Tax applicable to ursing Home
1.	21-17-03-476-00	2			\$	27,508.00	\$	27,508.00
2.					\$			
3.			<u> </u>		_			
4.								
5.								
6. 7.			<u> </u>		et.			
8.					<u> </u>			
9.					°-			
10.					s —		- s	
					_			
				TOTALS	\$	27,508.00	s	27,508.00
B.	Real Estate Tax	Cost Allocations						
	Does any portion used for nursing		to more than one nurs YES	ing home, vacant NO	propert	ty, or propert	y which is not	directly
			edule which shows the					ne.
C.	Tax Bills							

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Page 10A

CT	ГАТЕ	OF	TTI	TAL	OIC

					STATE OF ILLINOI	S				Page 11
	ity Name & ID Number Heritage				# 0041020	Report P	eriod Beginning:		01/01/2004 Ending:	12/31/2004
X. B	UILDING AND GENERAL INFO	DRMATI	ON:							
A.	Square Feet: 1	3,016	B. General Construction Type:	Exterior	brick/wood	Frame	wood		Number of Stories	
C.	Does the Operating Entity?	X	x (a) Own the Facility	(b) Rent from	a Related Organization	n.		(c) Rent from Completely Unro Organization.	elated
	(Facilities checking (a) or (b) m	ust comp	lete Schedule XI. Those checking (c)	may complete Schedu	ile XI or Schedule XII-	A. See instr	uctions.)		9	
D.	Does the Operating Entity?	X	x (a) Own the Equipment	(b) Rent equip	pment from a Related (Organizatio	n.	(c) Rent equipment from Comp Unrelated Organization.	pletely
	(Facilities checking (a) or (b) m	ust comp	lete Schedule XI-C. Those checking	(c) may complete Scho	edule XI-C or Schedule	XII-B. See	instructions.)		on chica organization.	
E.	(such as, but not limited to, apa	rtments,	this operating entity or related to the assisted living facilities, day training e footage, and number of beds/units	facilities, day care, in	dependent living facilit					
F.	Does this cost report reflect any If so, please complete the follow		ntion or pre-operating costs which a	re being amortized?			YES	XX	NO	
1	. Total Amount Incurred:				2. Number of Years (Over Which	it is Being Amor	tized:		
3	. Current Period Amortization:	-			4. Dates Incurred:					
·		_				-				
		N:	ature of Costs:							
			(Attach a complete schedule deta	uling the total amount	of organization and pr	e-operating	costs.)			
XI. (OWNERSHIP COSTS:									
			1	2	3		4			
	A. Land.		Use	Square Feet	Year Acquired		Cost			
			land			\$	43,000	1		
		L	Z TOTAL C			0	12.000	2		
			3 TOTALS			3	43,000	3		

0041020 Report Period Beginning:

01/01/2004 Ending: Page 12 12/31/2004

Facility Name & ID Number Heritage Manor-Colfax

XI. OWNERSHIP COSTS (continued)

R Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to a

FOR OHF USE ONLY		B. Buildi	ing Depreciation-Including Fixed Eq	_l uipment. (See inst	ructions.) Roun	d all numbers to near	est dollar.					
Beds		1		2	3	4	5		7	8	,	
4			FOR OHF USE ONLY									
S		Beds*		Acquired	Constructed		Depreciation	in Years	Depreciation	Adjustments	Depreciation	
6	4	60				\$ 840,000	\$		\$	\$	\$	4
Total	5											5
8	6											6
Improvement Type** 1995	7											7
9 1995 Improvements 1995 38,109 9 100 111 Remodel—Interior Walls 1997 7,439 111 12 Addition 1997 7,439 112 13 Paint/Remodel Resident Room 1996 1,728 13 Paint/Remodel Resident Room 1996 1,728 13 14 Kitchen A/C Unit 1996 3,125 15 15 15 15 15 15	8											8
10		Impro	ovement Type**	•								
11 Remodel—Interior Walls 1997 7,439 11 12 Addition 1997 5,229 12 13 7ain/Remodel Resident Room 1996 1,728 13 14 Kitchen A/C Unit 1996 3,125 15 15 15 15 15 15 15	9	1995 Improve	ements		1995	38,109						9
12 Addition 1997 5,229	10											10
13 Faint/Remodel Resident Room 1996 1,728			terior Walls									
14												
15												
16 Interior Remodel-Materials 1998 73,979 16 17 Roof Replacement 1998 67,876 17 17 18 Interior Remodel-Labor 1998 2,612 18 Interior Remodel-Labor 1998 2,612 18 18 19 19 19 19 19		Kitchen A/C	Unit		1996	3,125						
17 Roof Replacement 1998 67,876 17 18 Interior Remodel-Labor 1998 2,612 18 18 1998 2,612 1999 2,862 1999 2,862 20 20 21 Professional Fees 1999 1,900 21 22 23 24 Interior Remodel Materials 2000 12,700 24 25 25 26 27 Water Softener 2001 4,075 27 28 29 29 29 29 29 29 29												
18 Interior Remodel-Labor												
19												
20 ALTA Survey 1999 2,862 20 20 21 Professional Fees 1999 1,900 21 22 Water Temp Control 1999 1,440 22 23 24 Interior Remodel Materials 2000 12,700 24 25 Interior Remodel Professional Fees 2000 698 25 26 27 Water Softener 2001 4,075 26 27 28 Generator 2001 1,827 28 29 30 31 31 32 31 32 33		Interior Rem	odel-Labor		1998	2,612						
21 Professional Fees 1999 1,900 21 22 22 23 23 24 Interior Remodel Materials 2000 12,700 24 25 Interior Remodel Professional Fees 2000 698 25 26 26 27 Water Softener 2001 4,075 27 28 Generator 2001 1,827 28 29 30 31 32 32 33 34 C/O Allocation 31 35 Book Depreciation 44,114 44,114 359,158 35 35 35 35 35 35 35												
22 Water Temp Control 1999 1,440 22 23 24 Interior Remodel - Materials 2000 12,700 24 25 25 26 26 26 26 26 27 Water Softener 2001 4,075 27 28 28 29 29 29 29 29 29												
23												
24 Interior Remodel - Materials 2000 12,700 24 25 Interior Remodel - Professional Fees 2000 698 25 26		Water Temp	Control		1999	1,440						
25 Interior Remodel - Professional Fees 2000 698 25 26 27 26 27 28 29 2001 4,075 27 28 29 29 29 29 29 29 29					3000	13.700						
26 27 Water Softener												
27 Water Softener 2001 4,075 27 28 Generator 2001 1,827 28 29 30		Interior Rem	odel Professional Fees		2000	698						
28 Generator 2001 1,827 28 29 29 30 30 31 31 32 31 33 32 34 C/O Allocation 35 6,977 6,977 36 32 37 34 38 38 39 30 31 32 32 33 34 44,114 44,114 35 35 36 44,114 44,114 37 35 38 35 39 44,114 44,114 35 35		Water Cafter			2001	4.075						
29 30 30 30 31 31 32 33 33 34 C/O Allocation 44,114 44,114 359,158 35			er									
30 30 31 31 31 32 33 32 33 34 C/O Allocation 44,114 44,114 359,158 35		Generator			2001	1,027						
31 31 32 32 32 32 33 34 C/O Allocation							ļ	.	 	1		
32 33 33 34 C/O Allocation 6,977 6,977 34 35 Book Depreciation 44,114 44,114 359,158 35								-				
33 34 C/O Allocation 6,977 6,977 34 35 Book Depreciation 44,114 44,114 359,158 35					-							
34 C/O Allocation 6,977 6,977 34 35 Book Depreciation 44,114 44,114 359,158 35					-		-	-	-			
35 Book Depreciation 44,114 44,114 359,158 35		C/O Allocatio	on .						6 977	6 977		
							44.114			0,577	359.158	
	36	Door Depree					11,111	 	.,,		007,100	36

See Page 12A, Line 70 for total

^{*}Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

0041020 Report Period

 Report Period Beginning:
 01/01/2004
 Ending:
 Page 12A

 12/31/2004

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. Straight Line Depreciation Year **Current Book** Life Accumulated Improvement Type** Constructed Cost Depreciation in Years Depreciation Adjustments 37 38 Seal Parking Lot 2002 38 39 A/C Unit 2002 2,528 39 40 40 41 Exit Doors 42 Phone System 2003 41 2,892 5,958 1,941 42 43 A/C Unit 43 44 Water Heater 2003 44 4,375 2003 45 45 Friedrich Wallmaster 1,294 46 46 47 A/C Unit 2004 8,164 47 1,578 3,479 1,305 820 5,355 2004 2004 48 49 50 48 Window Glazing 49 Sidewalk 2004 2004 2004 50 Ansul System 51 Seal Parking Lot 51 52 53 52 Shower Room 53 54 54 55 55 56 57 58 56 57 58 59 60 60 61 62 62 63 63 64 64 65 66 66 67 67 68 359,158 70 TOTAL (lines 4 thru 69) 1,106,038 44,114 51,091 6,977 70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

STATE	OF II	LINOIS	3

Page 13 Facility Name & ID Number 0041020 **Report Period Beginning:** 01/01/2004 Ending: 12/31/2004 Heritage Manor-Colfax

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of	1		Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost		Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 234,37	8	\$ 21,735	\$ 21,735	\$		\$ 195,534	71
72	Current Year Purchases	10,33	5						72
73	Fully Depreciated Assets								73
74									74
75	TOTALS	\$ 244,71	3	\$ 21,735	\$ 21,735	\$		\$ 195,534	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		E. Summary of Care-Related Assets	1	2		
			Reference	Amount		Ī
	81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,393,751	81	
	82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 65,849	82	
	83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 72,826	83	**
	84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 6,977	84	
Γ	85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12L if applicable)	\$ 554,692	85	1

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

Fac	lity Name & I	D Number	Heritage Manor-Col	fax		STATE OF ILLINOIS # 0041020		ort Period Begin	ning: 01/01/2004	Ending:	Page 14 12/31/2004
XII.	1. Name of 1 2. Does the	and Fixed Equip Party Holding L	ment (See instructions.) ease: real estate taxes in addi	tion to rental ar	mount shown below on]NO				
		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option				
3 4 5	Original Building: Additions			\$				3 4 5	0. Effective dates of curre Beginning Ending		ment:
7	TOTAL			\$	**				1. Rent to be paid in futur rental agreement:	e years under t	he current
	This amo		tization of lease expense ted by dividing the total						Fiscal Year Ending 2. /2005 3. /2006	Annual R	ent
	9. Option to	Buy:	YES	NO T	erms:	*		1	3. /2006 4. /2007	\$	
	15. Îs Mova	ble equipment r	nnsportation and Fixed ental included in buildinable equipment:		e instructions.) Description:			eakdown of mov	vable equipment)		
	C. Vehicle Ro	ental (See instru	ctions.)								
17	1 Use		2 Model Year and Make	M	3 onthly Lease Payment	4 Rental Expense for this Period	17		* If there is an option to please provide comple		
18 19 20							18 19 20		schedule. ** This amount plus any		
_	TOTAL			\$		\$	21		expense must agree w		

		S	TATE OF ILLI						Page 15
Facility Name & ID Number Heritage Manor-Colf				# 0041	020 F	Report Period Beginning:	01/01/2004	Ending:	12/31/2004
XIII. EXPENSES RELATING TO NURSE AIDE TRAINING	PROGRAMS (See in	structions.)							
A. TYPE OF TRAINING PROGRAM (If aides are train	ed in another facility	program, attach a	schedule listing t	he facility name,	address a	nd cost per aide trained in th	at facility.)		
1. HAVE YOU TRAINED AIDES DURING THIS REPORT	YES 2.	CLASSROOM	PORTION:			3. <u>CLINICAL PO</u>	RTION:	-	
PERIOD?	NO	IN-HOUSE PR	OGRAM			IN-HOUSE PRO	OGRAM		
If "yes" places complete the newsinder		IN OTHER FA	CILITY			IN OTHER FA	CILITY		
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was		COMMUNITY	COLLEGE			HOURS PER A	IDE		
not necessary.		HOURS PER A	AIDE						
B. EXPENSES	ALLOCATI	ON OF COSTS	(d)			C. CONTRACTUAL IN	COME		
	1	2	3	4	ļ	In the box below facility received			
	Fa	cility						_	
	Drop-outs	Completed	Contract	Tota	al	\$			
1 Community College Tuition	\$	\$	\$	\$					
2 Books and Supplies		101			101	D. NUMBER OF AIDES	STRAINED		
3 Classroom Wages (a)		354			354				
4 Clinical Wages (b)	1					COMPLET	ED		

455

455

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(c)

(e)

5 In-House Trainer Wages

Contractual Payments

Nurse Aide Competency Tests

SUM OF line 9, col. 1 and 2

6 Transportation

TOTALS

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for

455

. From this facility

DROP-OUTS

1. From this facility

2. From other facilities (f)

2. From other facilities (f)

your own aides must agree with Sch. V, line 13, col. 8. (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Heritage Manor-Colfax # 0041020 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	` ' '	1	2	3	4	5	6	7	8	
		Schedule V	Staf	f	Outsid	le Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other t	han consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	\$		\$ 49,749	\$		\$ 49,749	1
	Licensed Speech and Language									
2	Development Therapist		hrs			18,777			18,777	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			59,016	130		59,146	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts				200,329		200,329	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					9,204			9,204	13
14	TOTAL			\$		\$ 136,746	\$ 200,459		\$ 337,205	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

0041020 Report Period Beginning:
As of 12/31/2004 (last day of reporting year)

XV. BALANCE SHEET - Unrestricted Operating Fund.
This report must be completed even if financial statements are attached.

		1		2 After	
		О	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	5,164	\$	1
2	Cash-Patient Deposits		2,963		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance		250,839		3
4	Supply Inventory (priced at)				4
5	Short-Term Investments				5
6	Prepaid Insurance		11,423		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)		(453,839)		8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	(183,450)	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		43,000		13
14	Buildings, at Historical Cost		1,106,038		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		244,713		16
17	Accumulated Depreciation (book methods)		(554,692)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):		5,484		23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	844,543	\$	24
	TOTAL ACCREC				
25	TOTAL ASSETS		((1.003		25
25	(sum of lines 10 and 24)	\$	661,093	\$	25

		1 O _l	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	44,528	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		2,963		28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		80,670		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		15,357		31
32	Accrued Real Estate Taxes(Sch.IX-B)		27,363		32
33	Accrued Interest Payable		2,712		33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36					36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	173,593	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable		722,502		40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	722,502	\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	896,095	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	(235,002)	\$	47
	TOTAL LIABILITIES AND EQUITY				
48	(sum of lines 46 and 47)	\$	661,093	\$	48

01/01/2004

Page 17 12/31/2004

Ending:

^{*(}See instructions.)

0041020

			1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	(264,182)	1
2	Restatements (describe):			2
3				3
4				4
5				5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	(264,182)	6
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)		29,180	7
8	Aquisitions of Pooled Companies			8
9	Proceeds from Sale of Stock			9
10	Stock Options Exercised			10
11	Contributions and Grants			11
12	Expenditures for Specific Purposes			12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment			14
15	Other (describe)			15
16	Other (describe)			16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$	29,180	17
	B. Transfers (Itemize):			
18				18
19				19
20				20
21				21
22				22
23	TOTAL Transfers (sum of lines 18-22)	\$		23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$	(235,002)	24

^{*} This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1		

	Revenue		Amount	
	A. Inpatient Care			
1	Gross Revenue All Levels of Care	\$	2,148,071	1
2	Discounts and Allowances for all Levels		(439,085)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	1,708,986	3
	B. Ancillary Revenue			
4	Day Care			4
5	Other Care for Outpatients			5
6	Therapy		328,579	6
7	Oxygen			7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	328,579	8
	C. Other Operating Revenue			
9	Payments for Education			9
10	Other Government Grants			10
11	Nurses Aide Training Reimbursements		3,868	11
12	Gift and Coffee Shop		636	12
13	Barber and Beauty Care		5,551	13
14	Non-Patient Meals			14
15	Telephone, Television and Radio			15
16	Rental of Facility Space			16
17	Sale of Drugs		228,985	17
18	Sale of Supplies to Non-Patients			18
19	Laboratory			19
20	Radiology and X-Ray			20
21	Other Medical Services		31	21
22	Laundry			22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	239,071	23
	D. Non-Operating Revenue			
24	Contributions			24
25	Interest and Other Investment Income***		79	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	79	26
	E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)			27
28				28
28a				28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$		29
1		ı		1

30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)

		Z	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	416,977	31
32	Health Care	1,070,966	32
33	General Administration	595,575	33
	B. Capital Expense		
34	Ownership	138,755	34
	C. Ancillary Expense		
35	Special Cost Centers	4,862	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		20,400	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,247,535	40
41	Income before Income Taxes (line 30 minus line 40)**	29,180	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 29,180	43

*	This must ac	ree with nage	4 line 45	column 4

**	Does this agree with	taxable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation.

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Manor-Colfax

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	(This senedule must cover the	1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	2,077	2,442	\$ 51,000	\$ 20.88	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	2,532	2,873	57,132	19.89	3
4	Licensed Practical Nurses	6,329	6,656	135,999	20.43	4
5	Nurse Aides & Orderlies	34,667	37,168	405,154	10.90	5
6	Nurse Aide Trainees	50	50	354	7.08	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			0		8
9	Activity Director					9
10	Activity Assistants	2,348	2,734	25,929	9.48	10
11	Social Service Workers	2,112	2,223	24,271	10.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	13,015	14,527	138,783	9.55	15
16	Dishwashers	ĺ		,		16
17	Maintenance Workers	2,060	2,157	30,697	14.23	17
18	Housekeepers	4,956	5,180	41,492	8.01	18
19	Laundry	4,267	4,577	36,554	7.99	19
20	Administrator	1,900	2,080	51,597	24.81	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,313	3,892	69,544	17.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
	Other(specify)					33
34	TOTAL (lines 1 - 33)	79,626	86,559	s 1,068,506 *	s 12.34	34

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		s 0		35
36	Medical Director		7,200		36
37	Medical Records Consultant		1,008		37
38	Nurse Consultant				38
39	Pharmacist Consultant		1,302		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,889		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		s 12,399		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$ 15,871		50
51	Licensed Practical Nurses		28,015		51
52	Nurse Aides		745		52
53	TOTAL (lines 50 - 52)		\$ 44,631		53
			•	•	

^{**} See instructions.

STATE OF ILLINOIS		Page 21

Ownersh %	ss	Amount 51,597 51,597 Amount	D. Employee Benefits and Payroll Description Workers' Compensation Insurance Unemployment Compensation Insurance Employee Health Insurance Employee Meals Illinois Municipal Retirement Funemployee Hepatitis Vaccine Employee Benefits - Employee Benefits - Employee Benefits - central office	e urance	Amount \$ 22,185	F. Dues, Fees, Subscriptions and Promo Description IDPH License Fee Advertising: Employee Recruitment Health Care Worker Background Check (Indicate # of checks performed Central Office Allocation Promotional Advertising Public Relations Dues and Subscriptions License and Fees Less: Public Relations Expense Non-allowable advertising	_ \$ _	Amount 0 2,728 234 2,205 3,731 2,155 4,638 1,982 (2,155) (328)
Function %	\$_ \$_ \$_	51,597	Description Workers' Compensation Insurance Unemployment Compensation Insurance FICA Taxes Employee Health Insurance Employee Meals Illinois Municipal Retirement Function Employee Hepatitis Vaccine Employee Benefits -	e urance	\$ 22,185 16,916 81,741 82,996 0 16,966	Description IDPH License Fee Advertising: Employee Recruitment Health Care Worker Background Check (Indicate # of checks performed Central Office Allocation Promotional Advertising Public Relations Dues and Subscriptions License and Fees Less: Public Relations Expense	_ \$ _	0 2,728 234 2,205 3,731 2,155 4,638 1,982
I. 1)		51,597	Workers' Compensation Insurance Unemployment Compensation Inst FICA Taxes Employee Health Insurance Employee Meals Illinois Municipal Retirement Fun Employee Hepatitis Vaccine Employee Benefits -	urance	\$ 22,185 16,916 81,741 82,996 0 16,966	IDPH License Fee Advertising: Employee Recruitment Health Care Worker Background Check (Indicate # of checks performed Central Office Allocation Promotional Advertising Public Relations Dues and Subscriptions License and Fees Less: Public Relations Expense	\$	0 2,728 234 2,205 3,731 2,155 4,638 1,982
	ss	51,597	Unemployment Compensation Inst FICA Taxes Employee Health Insurance Employee Meals Illinois Municipal Retirement Fun- Employee Hepatitis Vaccine Employee Benefits -	urance	16,916 81,741 82,996 0 16,966	Advertising: Employee Recruitment Health Care Worker Background Check (Indicate # of checks performed Central Office Allocation Promotional Advertising Public Relations Dues and Subscriptions License and Fees Less: Public Relations Expense	_ \$_ k _ =	234 2,205 3,731 2,155 4,638 1,982
			FICA Taxes Employee Health Insurance Employee Meals Illinois Municipal Retirement Fun Employee Hepatitis Vaccine Employee Benefits -		81,741 82,996 0 16,966	Health Care Worker Background Check (Indicate # of checks performed Central Office Allocation Promotional Advertising Public Relations Dues and Subscriptions License and Fees Less: Public Relations Expense	k	234 2,205 3,731 2,155 4,638 1,982
	ss		Employee Health Insurance Employee Meals Illinois Municipal Retirement Fun Employee Hepatitis Vaccine Employee Benefits -	d (IMRF)*	82,996 0 16,966	(Indicate # of checks performed Central Office Allocation Promotional Advertising Public Relations Dues and Subscriptions License and Fees Less: Public Relations Expense	<u>k</u> =	2,205 3,731 2,155 4,638 1,982
	s		Employee Meals Illinois Municipal Retirement Fun Employee Hepatitis Vaccine Employee Benefits -	d (IMRF)*	0 16,966	Central Office Allocation Promotional Advertising Public Relations Dues and Subscriptions License and Fees Less: Public Relations Expense	=) - 	2,205 3,731 2,155 4,638 1,982
			Illinois Municipal Retirement Func Employee Hepatitis Vaccine Employee Benefits -	d (IMRF)*	16,966	Promotional Advertising Public Relations Dues and Subscriptions License and Fees Less: Public Relations Expense	 	3,731 2,155 4,638 1,982
			Employee Hepatitis Vaccine Employee Benefits -	d (IMRF)*	16,966	Public Relations Dues and Subscriptions License and Fees Less: Public Relations Expense	 	2,155 4,638 1,982 (2,155
			Employee Benefits -		16,966	Dues and Subscriptions License and Fees Less: Public Relations Expense	 	4,638 1,982 (2,155
						Less: Public Relations Expense	 	(2,155
tely.)			Employee Benefits - central office		20,918	Less: Public Relations Expense	 	(2,155
	_	Amount				•	- - -	
	\$_ 	Amount				•		
	\$_	Amount				•		
	<u> </u>							1020
						Yellow page advertising		(3,731
			1			The state of the s		
			TOTAL (agree to Schedule V,		\$ 241,722	TOTAL (agree to Sch. V,	\$	11,459
			line 22, col.8)		·	line 20, col. 8)		
1. 3)	s		E. Schedule of Non-Cash Compens	sation Paid		G. Schedule of Travel and Seminar**		
ce agreement)	-		to Owners or Employees					
e agreement)			to owners or Employees			Description		Amount
Type		Amount	Description	Line#	Amount	Description		rimount
	•		Description	Line #	Amount ©	Out_of-State Travel	e	
rrees	Ψ_				<u> </u>	Out-oi-state Havei	_ "_	
		<u> </u>				In Canal Turnel		
						In-State Travel		1.655
								1,655
								54
						Seminar Expense		2,928
								(7,540)
		0						4,902
	_	1,075						
		0				Entertainment Expense	(
lumn 3)			TOTAL		\$	(agree to Sch. V,		
py of invoices.)	\$	143,709				TOTAL line 24, col. 8)	\$	1,999
T t	Fees umn 3)	Fees \$	Fees S 142,634 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Amount Description	Amount S 142,634	Amount Description Line # Amount S	Description	Description

Report Period Beginning: 01/01/2004 Ending:

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facilit	S y Name & ID Number Heritage Manor-Colfax	STATE (OF ILLINOIS 0041020	Report Period Beginning:	01/01/2004	Ending:	Page 23 12/31/2004
XX. G	ENERAL INFORMATION:			•			
(1)	Are nursing employees (RN,LPN,NA) represented by a union?	(13)		supplies and services which are of the Public Aid, in addition to the daily in			
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. Illinois Healthcare Association	<i>a</i> 6	•	ection of Schedule V? yes			٥
(3)	Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes	(14)	the patient census is a portion of the	building used for any function other listed on page 2, Section B? yes building used for rental, a pharmacy explains how all related costs were a	, day care, etc.)	For exampl If YES, attac	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?	(15)	Indicate the cost of on Schedule V. related costs?		assified to employ meal income be the amount. \$	een offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? yes 7 years	(16)	Travel and Transp	ortation ncluded for out-of-state travel?	no		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10		If YES, attach a	complete explanation. eparate contract with the Departmen	nt to provide med		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.		c. What percent of	this reporting period. \$ all travel expense relates to transpoage logs been maintained? yes			
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.		e. Are all vehicles times when not	stored at the nursing home during th			
(9)	Are you presently operating under a sublease agreement? YES xx NO	•	out of the cost re		_		no
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO xx If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over.		Indicate the a transportation	mount of income earned from p n during this reporting period.	providing such \$	h 	
		(17)	Firm Name: St	performed by an independent certifi laski & Webb	•	The instruc	yes tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 32,940 This amount is to be recorded on line 42 of Schedule V.			that a copy of this audit be included no If no, please explain.	Not available		
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.		out of Schedule V			-	
		(19)	performed been at	re in excess of \$2500, have legal invached to this cost report? yes d a summary of services for all arch		-	ices

State	1	Qual
CARRICKOCK CARRICKOCK-PAYROGA ACCOUNTS MICHICARES MEDICARI MICHICARES	1	and the same of th
DATE OF BUILDINGS BUILDINGS CONTROLS BUILDINGS CONTROLS BUILDINGS BUILDIN	UN UN ACCUMENTAL UN UN ACCUMENTAL UN UN ACCUMENTAL UN DE CONTRACTO	ecurs nas at
A BELIEVE AND A BELIEVE ACCUSED ON THE SEC. PROPERTY AND A SEC. PR	1,20 1,20 comm Mervano 1,00 1,00 command visitoria 1,00 1,00 command visitoria	PENER NY NE
PODE POLICIONY SUPERIORITATIONY LAND 41,000	Lam Lamitado	1000 1713 1706
ACCIDE DEPARTMENT DATES ACCIDE DEPARTMENT DISTRICT ACCIDE DEPARTMENT DISTRI	LON LONGONIA LA LON LONGONIA A LONGONIA	unite Local Local
ECHANISE (AS ECANOSE CAN DESCRIPTION BEAL SCIENT FAX DECRIPTION	UNI UNI CONCERNADO LAN LANGUAGO A SAN ACCORDO	100
DOTEACHMANY ARISES ACCOUNTS PAYMES AS OR BOOKERS PAYMES	100 100 ACCUSANCIAN 100 100 PCCCARRIGAN 100 100 PCCCARRIGAN	east draw M
ACCEPTANCE AND ACCEPT	2/20 2/2000C TARRESONN 2/20 2/2000C TARRESONN 2/20 2/2000CA WATER	LE USC PANAME
ENTERNAME OF THE PROPERTY OF T	210 210 CERT OF CCC	CHILD CHILD ANCE BERTHER
PAYROLL CAVINGS BA WING DINGS UNITED BASE	100 100	CAPETRIA
GREEP PORTRANCE PARVAILE CAPPERSON WARE CARPORATED TO MINE PARVAILL DEDUCTION	2300 2300 WANT GARROOM 2300 2300 ACCRESO 2300 2300 MARROOM	NI UND B
ACCUSED OFFICE PAYABLE 3/13 SOURT SAFANCARE 0 PAYABLE PAYABLE 0 BEAL OFFICE TAX PAYABLE 3/130	2,00 2,00 accument reach 2,00 2,00 compet reach 2,00 2,012,002,000	(Jail. Har ET BERET Hash
ACTIVITY FIND SECURITY SERVICES TOLLICIOSE FIND	DAM DAMEAGUE J.	UNIO SOME IO
CUBBLE PETER AND CUBBLE TAREFFEEDED	270 270 ACTION 2	OF LT DEBT LIBD LIBD
ENTERONCE POLITICAL POLITICAL COMMUNICATIONS COMMUN		_
DEPEND PLYON TOUR COMMUNICATION BITCHISTORY BETCHISTORY BETCHISTOR		
PATRICT DAVIGABLE (AND PATRICT DAVIGABLE) (AND PATRICT DAVIGABLE) (AND PATRICT DAVIGABLE)		Ser Services ser Ser Services GS Ser Services ser
PATRICT DAVIGATIONS PATRICT DAVIGATION PATRICT DAVIGATION PARTICLE		
THE CHARLES AND LAND AND AND AND AND AND AND AND AND AND		March Marc
I LEGIE NEBROGCARE JULIA I MERCHINERROGCARE I REAVY MERROCCARE		Total Committee (Committee Committee
I NUMBER GENERALE AND I NUMBER GENERALES AND I NUMBER GENERALES AND PLA		1960 1960 NEWSON (F. CO) 1960 1960 NEWSON (F. NO) 1960 1960 NEWSON (F. NO)
17 DESCRIPTION JOSEPH STATEMENT JOSEPH S		THE THE BROKEN (FT.70)
EPERAL EPERALDERANI PART A EPERALDERANI PART B		COLUMN TAXABLE COLUMN C
I SPEECHOLEPA THE		United the Color of the Color o
A SPECIOUS AND PART B DPA DRICORD BY AND PART B DPA DRICORD BY AND BORDORNO DRIED AND PART BORDORNO		LOS LOS MESCAS TONS LOS LOS LOS MESCAS TONS LOS
D MEDICANI DISCOUNTS DE MERICANICI TAX KOPENIE DE MEDICANICI DE MEDICANICI DE		Time Time Time Time Manager (CAM)
12 MCTOVETY PERSONNEL B 12 VERSENG ROCKHER EURORE AND 12 MARCHARLEST PERS		THE THE STREET OF
S RESERVE DATAPONE LATER ST.		ATTO ATTOCKA NEW ACTOR
ADMINISTRATION WALTER STATE ST		ADD ADDRESSES SHE ADD ADDRESSES SAN ADDRESSES SAN
EMPLOYIE COCCRESS ON 1,00 EMPLOYIE COCCRESS COC 1,00 DESCRIPTION		200 200 000000 100 200 200 000000 120 200 200 000000 100
TREMENT 1337 1337 TRANSPORT BYEL 1337 1337 1337 1337 1337 1337 1337 133		ACTS ACTS RECEIVED IN A LOSS ACTS ACTS ACTS ACTS ACTS ACTS ACTS AC
EDICATIONS FOR TEXAS. 10 EDICATIONS STREET, 100 MEPHANTEN ANTERIOR 170 PROMETERS ANTERIOR 170	1 10 Julius Julius 10 Juli	200 200 MARKET NA 278 200 200 MARKET NA 278 200 200 MARKET NA 278
PERSONAL PROCESSOR AND SERVICE	3 40	AND AND PERSONS SHEET AND AND RESIDENCE SHEET AND ADDRESS OF SHEET
PROFESSIONAL PRINT LAST LAST SAND MEDICAL DIRECTOR TORS 1 DOI: 1 DOI: 10.00 UTILIZATION REVENU	1.4	AND ANDMERSON LIFE AND ANDMERSON LIFE
MERICAL RECORDER CONTEXT 1,000 PROBABILITY 1,000 RECORDER TO 1,000 RECORDER TO CONTEXT 1,000 REC		AND AND PERSONS CONTROL OF THE PERSONS CONTRO
PURIODAL ADDI DECIMETARIS BANKSONICKI DIA BANKSONICKINICKI DIA	1 2)M	AND AND PAYMENT MICH.
PAYROLL TARRE ARABOUT (100 GREEP DOUBLANCE ELMS LIAMEDY POSTBANCE ELMS		AND ADDRESS TO THE
WORKSHOP COMP BUTTON I I I I I I I I I I I I I I I I I I I	100	AND ASSESSMENT HOUSE AND ASSES
LOST TERMICARISMOCK 0 MINICIAL ANGENCY MINICIAL TRANSPORT 1,000 20,000 LEARNING COMPANY 1,000 2,000		ACT ACT DAMES OF
MADERICAL SECTION STATES STATE		AND ADDRESS OF THE
NATIONAL GASE MACHINE A DESIGN CAL WATER & STREET TRANSCONDISCTOR 1)71 21:402		
MODELY KANTENNAME 100 1231 ORDERA MINISTA MART 26-01 MANUSCAN CONTRACT 2001 DETAIL TRACE		US CONTRACTO UN US CONTRACTO UN US CONTRACTO US
DETERMINED THE THE PART OF THE		CON CONSTRUCT TO S
MONERATOR AND THE COLUMN TO TH		OR CHEMINE 108 OR CHEMINE 148 OR CHEMINE 179 OR CHEMINE
LACKSON SECTION STATE SECTION		OH CHEMICAL (134) CHE CHEMICAL (134) CHE CHEMICAL (134)
LATHORY STREET TARRY TARRY TO THE STREET TARRY STREET TO THE STREET TARRY STREET TA		ON CHARLET 200 ON CHARLET 27 ON CHARLET 200 GO CARNESS NOT
DOUBLESSON STREET LOS HOSE BOURLESSON SERVICES (100 BOURLESSON SERVICES		Case Case SCHOOL 1/2 Case Case SCHOOL 1/2 Case Case SCHOOL 1/2
DO WALKER FILMS ADDR GOOD 6 BOOKEA VACABON 10,00		AND COMMONS INC.
DE WASHINGTON DE COURT DE COUR		ADD ADDITION DATE ADDITION TO THE
ADD WANTERSON MEDICANE PROFITS WANTERSON MEDICANE PROFITS		CON CONTROL TOTAL
ADE VICATION A SICK 20,600 CONTRACT NEBSELEN 20,601 CONTRACT NEBSELEN 20,601		CONTRACTOR OF CO
NUMBER AND TRANSPORTED IN		OT CTIMENS S OF CHARGE SIT OF CHARGE SIT
MINISTER B MINISTER VIC. 8 MINISTER BPT IDECATION:		OF CHARGES OF THE CO.
NUMBER COPICE 1407 Hydri NUMBER COPICE 1,00 BEPLACHBENT MERING 1,00 NUMBER COPIES 101 47,00		THE THE LABOUR SUC-
DESCRIBERATION RATE TO SELECT THE SELECT THREE SELECT THR		Too too actions upon too too actions upon too too actions so
HOME HEALTH SECLE VAC HOME HEALTH SERVICE ACTIVITIES WARRES 24 NO. 24 NO.		100 100
ACTIVITIES SEX A VAC (ASS ACTIVITIES SERVICES (ASS ACTIVITIES THE ACTIVITIES THE ACTIVITIES (ASS ACTIVITIES THE ACTIVITIES THE ACTIVITIES THE ACTIVITIES (ASS ACTIVITIES THE ACTIVITIES THE ACTIVITIES THE ACTIVITIES THE ACTIVITIES (ASS ACTIVITIES THE ACTIVITI		The Theodornal size
PERSONAL MANAGEMENT AND PROPERTY AND PARTY AND		Too Too Martin of the Too Too Too Too Too Too Too Too Too To
SECUL SERVICE SECULATION 12,000 10,071 SECULATION 1,000 SECULATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		The Checkwart specified by the Checkwart specifi
SECON DEPARTMENT A S SPECIAL DEPARTMENT AND S	17-	100 100 MINEST (N) 100 100 MINEST (N) 100 100 MINEST (N) 100 100 MINEST (N)
MANTENANCE AND		
TOE COMES GIVE A THE TOE COMES GIVE AND A THE TOE COMES GIVE AND A THE TOE COMES GIVE AND A THE TOE COMES GIVE A THE		
ACTURET EXPENSE 13,00 M,000 BORRECASON 41,00 M,000 LOANTIN AMORTIZATION (AN DETERMIT PACONE 3.0		
MINIC NOT CONTRACTING SHOOM 9 SAME TAKEN TAKEN 34,000 1,007,000		
USAN JOHN (METHODAL)	M, III	
FACELY COST. FACELY D: 6		
29 GL BRCAP 29 G, 201 G	MACK.	
DA MEDICAL DE 10 10 10 10 10 10 10 10 10 10 10 10 10		
PECONOMIC AND		